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Evans, EA, Perkins, E, Clarke, P, Haines, A, Baldwin, A and Whittington, R (2018) Care home manager attitudes to balancing risk and autonomy for residents with dementia. *Aging and Mental Health*, 22 (2). pp. 261-269. ISSN 1360-7863

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**Downloaded from:** <https://e-space.mmu.ac.uk/621294/>

**Version:** Accepted Version

**Publisher:** Taylor & Francis

**DOI:** <https://doi.org/10.1080/13607863.2016.1244803>

Please cite the published version

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## **Care home manager attitudes to balancing risk and autonomy for residents with dementia**

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**Acknowledgements:** We are sincerely grateful to the care home staff who participated in the interviews. This work was supported by the 5 Boroughs Partnership NHS Foundation Trust.

# Care home manager attitudes to balancing risk and autonomy for residents with dementia

Aging and Mental Health

**Objective:** To determine how care home managers negotiate the conflict between maintaining a safe environment while enabling the autonomy of residents with dementia. This is important because there is limited research with care home managers; yet, they are key agents in the implementation of national policies.

**Method:** Semi-structured interviews were conducted with 18 managers from care homes offering dementia care in the Northwest of England. Data were analysed using a thematic analysis approach.

**Results:** There were three areas in which care home staff reported balancing safety and risk against the individual needs of residents. Firstly, the physical environment created a tension between safety and accessibility to the outside world, which meant that care homes provided highly structured or limited access to outdoor space. Secondly, care home managers reflected a balancing act between an individual's autonomy and the need to protect their residents' dignity. Finally, care home managers highlighted the ways in which an individual's needs were framed by the needs of other residents to the extent that on some occasions an individual's needs were subjugated to the needs of the general population of a home.

**Conclusion:** There was a strong, even dominant, ethos of risk management and keeping people safe. Managing individual needs while maintaining a safe care home environment clearly is a constant dynamic interpersonal process of negotiating and balancing competing interests for care home managers.

**Keywords:** care homes; dementia; risk; autonomy; manager attitudes

## Introduction

It has been estimated that 39% of those with late-onset dementia in the UK live in a care home (Alzheimer's Society, 2014). UK care homes traditionally are subdivided into residential (without nursing) and nursing subtypes, with 'elderly mentally infirm' (EMI) home status indicating provision of specialised care for dementia and/or mental health (Stewart et al., 2014). Of those with dementia who live in care homes, 58% live in residential care and 42% live in nursing homes (Alzheimer's Society, 2014). The increase in prevalence of people with dementia in care homes has put a spotlight on the need to provide a person-centred approach to dementia care. Kitwood avers that this should be maintained through social relationships with staff and informal carers to ensure that people do not lose their sense of personhood or selfhood (Kitwood, 1997). The perspective of the individual is seen as the starting point for care that recognises the need for an enriched social environment, which both compensates for impairment and fosters opportunities for personal growth (Brooker, 2011). There is clear robust evidence to support the benefit of person-centred care training in improving the clinical outcomes of people with dementia living in care homes (Fossey et al., 2014). However, these ideas appear difficult to sustain in care home practice (Brooker, 2011) and care for people with dementia in care homes is not of a universally high standard (Alzheimer Scotland, 2008).

It is possible to identify two dominant, seemingly contradictory themes in the discourse and practice in relation to the provision of care in this setting. On one hand there is a paternalistic and regulatory concern with the safety of residents. On the other hand there are demands from advocacy groups and policy makers not to lose sight of the individual as a free agent. The Care Quality Commission (CQC) promotes a safety first approach, in which risk is minimised, alongside positive risk taking or enabling residents to maintain some independence (CQC, 2015). For example, a safety first approach could mean minimising risk of falls by not enabling freedom of movement. In contrast, positive risk taking transcends the physical components of risk to factor in the effects on wellbeing if a person with dementia is restricted and unable to do something. In order to provide person-centred care, risk management should involve balancing the potentially positive benefits of taking risks with the negative effects of attempting to avoid risk in order to maintain safety (Department of Health, 2010). Thus, care home staff must balance a positive approach to risk-taking with their professional and statutory duties to protect service users in a safe environment. This tension has been recognised by other authors, to be discussed below; however, to the best of

our knowledge no study has yet looked at how care home managers negotiate this tension and balance these competing demands. In other settings, the merits of positive risk management have been put forward in Department of Health (DH) policy statements (Department of Health, 2004a, 2004b, 2010) but few attempts have been made to examine the concept and its potential benefits empirically (Robertson & Collinson, 2011).

In the literature, two key elements underpinning the wellbeing of care home residents are the design of the physical environment and the selection and management of staff. Much previous research in this area in the UK has focused on the care home environment and how space is structured and managed. Ambient light levels, especially from natural sources, are an important aspect and can reduce distress from illusory perceptions. DH national minimum standards state that all core areas of a home must be accessible, including gardens (Department of Health, 2006). A study of 38 dementia care homes in Sheffield aimed to assess the impact of the building design on the quality of life of residents (Torrington, 2007). Those homes that scored highly in health and safety terms tended to have relatively low levels of resident wellbeing and opportunities for pleasurable activity. For example, often there were high levels of staff surveillance and restriction of free movement (e.g. keypads and heavy fire doors) in 'safe' homes including limited access to outside space where residents could spend time (Torrington, 2007).

Clearly care home design needs to allow as much access to the outside world as possible (Chalfont, 2008). Yet, going outside can be a challenge both to care home staff and for residents with dementia. In a study of care home design and the values of people with dementia and their family members, residents reported feeling controlled and wanting to be allowed to go outside or to move around the home and grounds. So while people with dementia have a human and legal right to autonomy, safety issues limit the extent to which these rights are facilitated (Innes, Kelly, & Dincarslan, 2011). Often it is assumed to be too risky to allow people with dementia to make their own choices and decisions (Kelly & Innes, 2013).

The DH's minimum standards for care homes emphasise that the residents' capacity to exercise personal autonomy and choice should be maximised and that routines of daily living and activities should be flexible and varied. Yet, a preoccupation with risk was found to be one of the barriers to implementation of psychosocial interventions in dementia care homes from a synthesis of 39 qualitative papers (Lawrence, Fossey, Ballard, Moniz-Cook, &

Murray, 2012). Priority in the scrutinised homes was given to aspects of physical care and safety at the expense of promoting autonomy so that activities or behaviours that were perceived as potentially harmful were actively discouraged (Lawrence et al., 2012).

While maintaining a safe environment often is the priority for staff, residents with dementia and their relatives have expressed concern about their lack of choice and flexibility (Train, Nurock, Manela, Kitchen, & Livingston, 2005). Activities were observed in this study but were restricted and some gardens were underused due to access difficulties or insufficient staff to accompany residents. The need for flexibility and autonomy again raised the recurrent dilemma of balancing risks with rights (Train et al., 2005).

Popham and Orrell (2011) in their study of care home managers, staff, residents and family members also reported divergence between staff and residents' views on the importance of safety versus independence. Whereas residents did not mention health and safety issues, care home staff saw these as a top priority. As a result, access to gardens was heavily restricted because of the safety concerns of staff yet many residents felt they would have liked to be able to choose when to go outside (Popham & Orrell, 2011).

Actual and potential falls are a major concern driving the ethical dilemmas in this area (Johansson, Bachrach-Lindstrom, Struksnes, & Hedelin, 2009). People living in care homes fall more frequently than older people living in their own homes (Johansson et al., 2009; Walker et al., 2015); however, this may be unsurprising as being admitted to a care home can be an indicator of frailty and of a higher baseline risk of falls (Deandrea et al., 2013). Best practice guidance published by the DH emphasises that care home staff should take a person-centred approach to risk that does not assume that a diagnosis of dementia renders all individuals at equal risk (DH, 2010). However, some evidence suggests that person-centred care was actually associated with an increased risk of falls (Brownie & Nancarrow, 2013). Although these findings were based on small studies, it highlights the dilemmas care home staff face when providing person-centred care that may result in injuries to residents.

Deprivation of Liberty Safeguards (DoLS) were introduced under the 2005 Mental Capacity Act (MCA) and provide a legal framework to ensure that the liberty of people lacking capacity is restricted only when it is in their best interests and other options are not available. However, the CQC has identified amongst care home staff a continuing lack of understanding and awareness of the MCA including DoLS and their use (CQC, 2015). An investigation into the use of the Act in five care homes found that lack of an understanding of the Act by care

home staff can mean that they may be at risk of contravening some of its core principles, despite feeling that they are making decisions in an individual's best interest (Manthorpe, Samsi, Heath, & Charles, 2011). In a follow up study, although knowledge of aspects of the MCA had improved among care home staff, decision making often was deferred to senior staff. Indeed, managers were the most confident in their knowledge of the MCA; yet the authors cautioned that this was no guarantee that senior staff are experts in this area (Manthorpe & Samsi, 2014).

Legal responsibility for regulation compliance is shared between care home managers and owners and, therefore, care home managers have substantial managerial, commercial as well as legal responsibilities (Orellana, 2014). In a scoping review of research about and involving care home managers, it was found that the sector is known for its low status, poor pay, limited career prospects and in which recruitment and retention are major difficulties (Orellana, Manthorpe & Moriaty, 2016). Consequently, managers described their role as stressful with stress characterised as being accountable to potentially multiple bodies, which included owners, regional managers, commissioners, inspectors, and residents or their family members. These multiple demands may result in tensions and impact on the effectiveness of managers (Orellana et al., 2016). Yet despite increasing levels of responsibility and the importance of their role in the lives of so many older people, care home managers experience a lack of status and recognition as a profession (Orellana et al., 2016).

As shown, the sociostructural environment impacts on the delivery of person-centred care. But it is not known how care home managers, who are key agents, construct risk and negotiate the conflict between risk and the rights of individuals for whom they are responsible. As managers are the conduit between provider philosophy and promoting best practice delivery of care, it is crucial that we understand how they negotiate the conflict between maintaining a safe environment while meeting the needs and enabling the autonomy of residents with dementia.

## **Methods**

This research is based on data from a qualitative, semi-structured interview study conducted between March and July 2014 evaluating a care home liaison service pilot project at an NHS trust in the Northwest of England. The focus of the original study was examining the effectiveness of the pilot project in which specialist staff supported care homes in responding to a range of problems including challenging behaviour by residents. The overall evaluation



included the interviews analysed here alongside quantitative data on service delivery (e.g. prescribing patterns). The focus on conflict in the interviews was underpinned by the literature which suggested that care of people with dementia was often associated with conflict. Although the original focus of the interviews had been on the conceptualisation and management of conflict in care homes catering for residents with dementia, the findings identified a strong ethos of risk management and keeping people safe. These findings along with national standards and guidelines for best practice (e.g. CQC; DH; NICE) underpinned the focus of the current study. The study reported here aimed to address the following questions: what do care home managers consider risk to be? How is this risk managed within the care home? What are the consequences (for both residents and staff) of being risk averse? The study received ethical approval from the University of Liverpool (ref. IPHS-1314-LB-254).

### ***Recruitment***

Care homes offering dementia care in the Northwest of England were identified through an online register of care homes (carehome.co.uk) that lists registered care homes in the UK. A purposive sampling framework was devised to ensure that respondents were recruited from a wide range of dementia care homes within the study location. Twenty care homes were selected on the basis of the following variables: the provision of nursing care (yes/no); size (small, <41 beds; medium, 41-55 beds; or large, >55 beds); and type of provider (not-for-profit; small private; or large private). Managers and (in their absence) senior staff members were identified from each selected care home as potential respondents.

Managers of the selected care homes initially were contacted by telephone and/or letter. Those who expressed an interest in taking part were sent a respondent information sheet and re-contacted once they had had time to read it. Before being interviewed respondents were asked to give informed consent by completing two copies of the consent form, one of which they kept. Only two of the 20 care homes approached declined to participate. One respondent from each of the remaining 18 care homes was recruited. See Table 1 for respondents and care home settings.

[Table 1 about here]

There were 16 female and 2 male respondents, all but one of whom were white. Twelve of the 18 respondents were managers, two were deputy managers and four were senior carers.

**All respondents had many years' experience of working in care homes; of those who specified number of years ( $n=11$ ), there was a mean of 23 years and a range of 7 to 35 years.**

### ***Data collection***

Semi-structured interviews were conducted with respondents to explore their understanding of conflict and aspects of conflict management in the care home setting. Each interview took place in the care home in which the respondent worked and at a time that was most convenient for them. Participants were asked to articulate their understanding of conflict in their care home, to describe conflict behaviours and to discuss how the environment helped or hindered residents, how conflict situations were dealt with and the factors that affected how they deal with people with dementia. The interviews were audio recorded. The interviews lasted between 22 and 110 minutes with a mean length of 54 minutes. Recordings were transcribed by a university transcribing service, and checked and anonymised by the researcher.

### ***Data analysis***

A thematic analysis approach (Braun & Clarke, 2006) was taken in which data were coded line by line, interrogated and categorised. Transcripts were read through for familiarisation and immersion and to create an initial list of ideas using those that emerged in the original study as a starting point. Then transcripts were coded line by line to identify features of the data and these codes were grouped together to create themes. Through a process of re-reading and consultation with colleagues, these themes were refined and interpreted. A process of constant comparison enabled the emergence of concepts that were examined in the context of other transcripts. Patterns were identified and differences and similarities between groups were examined. Numbers attached to quotes below refer to individual respondents.

### **Results**

There are three areas in which care home staff report that they were required to balance safety and risk against the individual needs of residents. These are the physical environment, preservation of dignity, and the individual versus the group. Each will be discussed below.

#### ***How individual risk is structured in the physical environment***

Given that care homes are places in which people live it is not surprising that access to outdoor space is considered to be important. Although DH (2003) minimum standards state that grounds should be safe and accessible to service users, this is seen to pose particular problems for service providers who recognise the tension between safety and accessibility for some groups of older people. As a consequence, care homes either structure their outdoor space with safety in mind or structure access to it. They do this in a number of ways and access often is controlled by locking doors or using doors with keypads. It is also restricted by the availability of staff to accompany service users: 'We do bring people, they've got their own garden [...] but they are always escorted, all escorted [...] it's key-padded,' (11).

While the language of accessibility was frequently used by care home managers with assertions that residents were free to go outside, this freedom often could only be exercised if residents requested access to gardens. Underpinning this restriction was the need to ensure the safety of residents who wanted to go outside as well as the residents who needed to be kept inside:

There's a big garden at the back, we have a little one for [Unit] and they have tried to get over that so probably see that as a barrier [...] they can come in one end of the building and go out the other to a secure garden [...] if the door's open, it's a handled door. (10)

They've got patio doors that go onto the gardens which are locked unless they ask for it to be left open so they can potter out and when they come back in we can lock them again so they've still got that security. It's not open. (16)

Care homes seemed to operate with different levels of acceptable risk. This may have depended on the facilities and location as well as on individuals. One manager discussed the need to obtain Deprivation of Liberty Safeguards (DoLS, which were introduced under the 2005 Mental Capacity Act) for her residents because of the danger caused by being on a main road:

Obviously I have to have a key code, it is because if somebody with dementia got out and was able to open the front door [...] there's a main road you're looking at the health and safety so it's not actually deprivation but unfortunately because this new deprivations just coming out now the new one that is actually saying care homes have a key code have to change the support plans now and put a DoLS in for everybody which

we've just started doing, it's because it's a deprivation that you are not letting them go out. (15)

It is clear that this respondent regarded restricting movement as being an infringement of rights that had to be balanced with ensuring the safety of the residents. But that restriction applied to the front door and not to the secure garden:

They can go into the garden [...] it's a fenced off and also we've got an alarm button on the patio, so when the patio doors are shut say at night if somebody wandered into the bedroom and opened the patio the alarms would go off to let somebody know that they're going in the garden at night so that's all in place. (15)

Some of the homes allowed access to gardens only in good weather but, again, residents were supervised for their safety: 'They go out in the summer but obviously they have to be supervised because of the risk of trips and falls,' (3).

The homes that required outside supervision for residents were constrained in their ability to provide this by staffing levels. It is plausible that individualised person-centred care often is compromised by the needs of the wider group. The level of risk posed by going outside unaccompanied may be made on an individual basis taking into account a person's mobility:

Like today it's a beautiful day so the doors are open so we've got about half a dozen who we feel quite happy who can mobilise around the gardens quite simply and independently, so they can. [For others] we would need to go with them just to give them that support. (16)

Access to outside space was recognised by some of the care home managers to produce a noticeable effect on the moods of residents: 'In the good weather you know, try and get vitamin D and it lifts their spirits,' (5). This particular care home had made provisions for outside access all year round:

We've got a lovely garden and a nice summer house and it's heated and it's got lighting in so they use that quite a bit. Even in the winter, we use it yeah, they feel like they've been out you know. (5)

However, at this care home freedom of movement was limited to ground floor residents. Whether people were allocated rooms upstairs or downstairs was a decision made at pre-admission assessment meetings and was based on 'whether or not they had dementia and

were mobile'. Those people with dementia who were mobile were not allocated ground floor rooms as 'it wouldn't be fair on them 'cause it would be too dangerous.' Although this respondent did not say specifically what would be dangerous, it is implicit in her remarks that allowing mobile people with dementia to freely access outdoor space would be a challenge to providing a safe environment:

We don't lock the doors here people can come and go as they like so if you've got somebody who's got a dementia and is mobile I wouldn't even consider them for the ground floor, they'd have to wait until a room came available upstairs [...] but to be honest if they're mobile I'm more reluctant to take them simply because, in the winter it's not as bad but like now as you can see the door's wide open there [...] they can come and go as they like, we don't lock anybody in. (5)

As this home allowed its downstairs residents the freedom to move around both indoors and outdoors, residents with dementia were assigned to rooms upstairs for their own safety. This was seen at another care home with more than one floor: 'I think it helps down here because you've got access to the gardens, I think upstairs you don't have access to the gardens,' (12). While this manager recognised the importance for residents to 'actually feel that fresh air', it became apparent that this was a flexibly held value such that upstairs residents could only experience this benefit if there were the staff available to escort the resident downstairs. The manager reported the low probability of this actually happening, 'that can happen' but it does not occur regularly. In other two-floor care homes the challenge of providing outdoor access was managed through the use of balconies: 'People have a safe balcony area that people can go outside and have that space you know,' (11);

The households on the upper floors they have balconies which are obviously, they are decorated in the same fashion [as downstairs areas] but more with pot plants and they have seating areas out there as well [with] patio doors. (17)

There were examples of care homes that appeared to bridge the need for safety with access to an outdoor environment by bringing the outside in. For one care home that involved the creation of an indoor street area with a functioning shop: 'sweet shop yes, it's not a tuck shop it's actually meant to be a road, there's a hairdressers on the same wall, there's a shop, it had opening times, the shop is run by the residents,' (7). Other care homes created areas within the homes that mimicked the outdoors:

On the mixed unit next door because some of our service users can't get down to the garden we've brought the garden in. So we've got like a garden area and the other mixed unit down stairs we've got a seaside theme so we've got buckets and spades and flip flops and what have you. (6)

However, the creation of these spaces textured by objects from other places and locations were held responsible for an increase in distress and agitation on the part of residents. As one manager put it: 'We've had a massive increase in the amount of aggression towards physical objects because there's lots of stuff round,' (3). Rather than viewing these spaces as therapeutic this particular respondent perceived these as providing more opportunities for objects to be used as missiles:

We've got a beach erm a beach themed corridor on one part of the unit and we've got again like a wooden garden chair that's mean to be like a summer chair that you'd have on the beach erm and that is constantly getting launched down the corridor. [...] We've got a garden area in one of our corridors and we had, there's a bucket pinned up, on it was one of these objects that, for them to interact with, there's a bucket pinned up on the side and that got launched erm a metal bucket launched at, not a big one but a metal one with a plastic topiary thing in and that got launched down the corridors this week. (3)

Other adaptations to the environment were also in place reportedly to minimise the distress of the residents:

What we understand now in terms of EMI environments and dementia environments is to disguise the doors so that they don't recognise it's a door because if they see a door then they are obviously going to try and get out so we try to disguise what the doors look like erm and even, and this is sad, even a lot of the windows are frosted [...] to stop them from looking out because that causes them distress because they want out so then, so then in the past, in previous experiences somebody'd pick up, 'I want to get out,' when they can't open the window they pick the vase up and put it through the glass. (3)

The respondent hints at a shared knowledge of best practice in specialist 'Elderly Mentally Infirm' (indicating specific care for dementia and/or mental health) care homes to underpin the practice of disguising doors, which was seen as being in the best interests of residents. Arguably this reflects a lack of understanding of the needs of people with dementia in care

homes who are faced with a struggle to maintain a sense of health and wellbeing. Residents not only have to contend with declining cognition and an increased need for familiarity, they have to cope with a novel and often unpredictable care environment (Brooker, 2011). In the above example, although frosted windows were used to prevent risk of harm to the individual (and to property) this practice came at the expense of personal autonomy and of providing an environment that was connected to the outside world.

### ***Preservation of dignity and threats to autonomy***

Care home providers have a duty to protect their residents' dignity but also to enable residents to exercise their personal autonomy and choice. The need to maintain these rights was well understood by managers but not always by frontline staff. One manager discussed the difficulty of managing communications between carers about individual residents:

Some of the time I hear things and I just cringe. [I will intervene] if it's in front of relatives and things, though I am quite sort of shy about it and will say to somebody on their own 'do you need to say that out loud?' Or they'll shout right across the room 'Jo needs the toilet' and you're like ohh God. (8)

Examples such as this suggest that the dignity of individuals is not always preserved by frontline staff. But arguably the delivery of person-centred care must be driven from the top down. This manager recognised such practice as inappropriate and was sensitive to both residents and staff members yet possibly was not displaying the necessary leadership skills to rectify it. Conveying to staff the need to protect residents' dignity was addressed in different ways by different care home managers:

[I tell them] would you want to come and see your mum you know at 11 o'clock in the morning and her mum's sat there with tea stains on her tee shirt and porridge on her mouth? You know that somebody's just not gone and changed her blouse and wiped her mouth. (15)

The balance between promoting dignity and causing distress was most apparent when providing personal care to residents, which was reported to be handled by returning to try again later:

Refusing personal hygiene, well we try and promote independence even with people with dementia it's their person, we'll assist with them from the sink up and remind

them what they need to do. Putting their clothes in order for them on the bed and you know what if they did not manage to put their shirt on the right way and you've got to help and it gets them distressed, what's the harm in leaving them as long as they're happy and content. If they're soiled and you know that's not the type of person to spill food down them and they don't want to change their jumper, leave them, come back half an hour later. Don't pester them about it. (10)

While a common approach was returning to a resident later when that person may be more receptive to assistance, care home staff must balance the need to provide personal care with the need to enable individual autonomy. For instance:

Refusing to get out of bed now this is a big one for us really because during the [Y] Project we were very much firmly encouraged if they don't want to do it then they don't have to do it. So then we got into the situation where people were just lounging in bed all day festering in their own urine and faeces and stuff like that and the staff took it really literally, rather than maybe encouraging [...] they were saying 'oh they don't want to get up; we don't have to wash and dress them today' do you know what I mean, so really they took that to an extreme [...] but it's not about going in at 6am in the morning and getting everybody up by 8 which is very, very care home, old-school nursing mentality. (18)

Residents not wanting to get out of bed was a common cause of conflict, which, again, often was managed by returning later. However, the example above highlights the balancing act between allowing a resident freedom to choose whether or not to get up and the level of risk to an individual (in this case, personal hygiene).

Balancing autonomy with provision of care requires continuous reassessment of whether a care home can meet the needs of individual residents. Residents acting in ways that are considered aggressive or socially inappropriate are often labelled as challenging behaviours, for which decisions are defended in language that stresses the best interests of the individual. For example, a resident displaying inappropriate behaviour may be cause for relocation to a different facility. As one manager put it: '[this home is not] the right environment for them because you've got to protect that person's dignity,' (10). This point was illustrated by describing the distress of one former resident that led to his relocation:



He was constantly distressed arguing with the reflection, throwing things at it, not recognising what a toilet was for any more, so he was urinating in inappropriate places [...] the resource it had on us was extra staff to try and do one-to-one and to show him, because a lot of protecting his dignity as well against others and visitors and other residents, because not everybody has an understanding [...] and in the end he had to go to nursing where the staff levels are higher. (10)

This individual's behaviour was reported to have had an impact on other residents and required more staffing resources. Ultimately he was moved to a facility that could accommodate him better. However, the reason given for his relocation was the protection of his dignity. Thus, this reflects a balancing act between the individual's autonomy and the need for care home staff to protect their residents' dignity.

### ***How the needs of one resident are balanced against others***

One of the challenges of providing person-centred care in a care home setting was balancing the needs of the individual with the needs of other residents. As explained by one manager, this process began prior to admission with an assessment of the extent to which an individual might fit with the current population of the home:

We have to be, to take everybody else into consideration when we are going out to do our assessment, look at personalities, will they fit in with the people that already live here? Because we have to be mindful that this is their home at the end of the day so I haven't actually refused anyone but you do have to be mindful of that when you go out. (13)

Even with pre-assessments to determine a good fit, personality clashes did occur and generally were managed by keeping individuals apart:

You can identify quite quickly anybody who is going to sort of have a personality clash with somebody else or if that person's got a behaviour that will trigger a negative behaviour in somebody else then we would keep them apart. We'd deliberately not put them together. (16)

This required managing residents in the space available by trying to keep individuals in different areas as a preventative measure. However, this required judgements about the needs of the individuals involved in a personality clash:

When they start taking it out on each other and they say somebody's took something that's not theirs and start hitting each other, conflict comes into it that way, then that's where we have to think you know it's affecting more than one person, what is the best for both of them at that time. (10)

Moreover, simply separating individuals was not straightforward particularly if the personality clash involved a staff member:

If you've got one staff member what's upsetting one resident and yet six of the other residents get along with this staff member and interact better, six other residents are losing out so you have to balance that as well. (10)

In this example, the implication is that meeting the needs of one resident (perhaps by assigning the staff member elsewhere) would be at the expense of residents who could get along with that staff member. This notion that meeting an individual's needs could come at a cost to others was seen elsewhere. In the following example, when faced with a woman presenting with challenging behaviour, this manager seemed to give in to the resident's need to go outside because the costs of not acceding to her desires were much greater:

So in the end I said to my colleague will you take her outside, now I can only do that today and I've done, she's gone out for half an hour at the expense of everybody else having an activity this afternoon 'cause that one person is off. (3)

Juggling staff as a resource against the needs of the individual seemed to be a daily occurrence in care homes. Mostly, the juggling was to meet physical needs but there were occasions in which the emotional needs of the residents forced the redistribution of staff priorities:

If we've got to remove someone or if we've got to separate people out you're talking two or three staff [...] so if we take 5, 10 minutes out to deescalate, three members of staff to deescalate that situation there, that's one person on the floor for 22 other people, it might be two or three people yeah so, and that's 10 minutes there and while that's happening over there those three have started over there. (3)

The respondent continued by stressing that attending to the needs of one resident could result in increased risk of harm to other residents:

What I feel is in terms of managing violence and aggression is that to do it properly and to do it safely would take all of our staffing resource at that time and leave the rest of the clients [...] while we're dealing with that violent incident over there where there's risk of serious injury to somebody, over there that person who's unsteady on their feet has fallen over there because we weren't there to stop them from falling. (3)

For homes without nursing care, an individual's needs may outweigh the care that can be provided:

When they get residents who present with challenging behaviour more often and we're unable to meet the needs it's because we haven't got that level because they need a more one-to-one basis or nursing needs come into it then, they are moved to alternative care unfortunately [...] because it has an impact on the other residents so you don't want that. (10)

So, in cases where attending to the needs of one impacted too greatly on the other residents, an individual presenting with challenging behaviour may be relocated:

I actually had her detained under the Act and we had her taken over to [Hospital], she went to [Hospital], when they asked us to take her back we said no, not because we couldn't handle her because yes we could, we chose that it would not be fair on the people that lived here. [...] It's very much a utilitarian decision-making process for the greater good of all. (7)

Interestingly, this manager claimed to have been able to provide person-centred care to meet the needs of the former resident, yet clearly chose not to do so because of the impact on others. Although needing to relocate individuals was not a common occurrence the practice further reflected the continual balancing of individual needs with those of other residents and how an individual's needs were subjugated to the needs of the general population of a home.

## **Discussion**

This paper has shown some of the challenges care home staff faced in the delivery of the person-centred care that is described in policy documents and professional rhetoric. The focus has been on how care home managers construct risk and struggle to balance the rights of individuals with the need to keep them safe. Risk is negotiated and managed within staffing and environmental limitations; thus, there is a tendency to err on the side of caution.

While it is justified that care home staff ensure the safety of their residents, there is the danger of people being kept so safe that they have no quality of life (Brooker, 2007). A further challenge was that of providing care that enables autonomy and promotes dignity while minimising distress for individuals. Again, a preoccupation with risk can be a barrier to maintaining these rights, as has been suggested by others (Lawrence et al., 2012; Train et al., 2005). A frequent dilemma arose when the rights of one individual were at odds with the safety and comfort of others. Balancing the needs of one individual against those of the wider group can be one of the most difficult situations faced by staff and residents in long-term settings (Brooker, 2007).

The findings identified a strong, even dominant, ethos of risk management and keeping people safe that is simultaneously prioritised by regulatory agencies, creating a real tension between risk management and autonomy at the level of both policy and practice. This ethos of maintaining safety often resulted in practices that arguably could be deemed to infringe residents' right to liberty. This was evident particularly when maintaining a safe physical environment came at the cost of enabling freedom of choice. There was an organisational ethos to protect residents as a group rather than as individuals, which was reflected in the way in which the environment was structured.

The tension between safety and accessibility to the outside world meant that care homes provided highly structured outdoor space or limited access to outdoors completely. There were commonly used restrictions such as locked doors, keypads, spatial segregation or restrictions on unescorted outdoor access and these were justified by the need to ensure safety at all times. This highlights the conflict for staff between the management of risk and the loss of control residents have over their lives. The importance of having access to outdoor space has been stressed before (Chalfont, 2008) and it has been found that care homes that prioritised safety had a negative impact on quality of life (Torrington, 2007). This could be seen in this study as well, with increased distress and agitation attributed to the creation of artificial outdoor areas within one of the homes.

Such practice could be counter-productive and by leading to behaviours that it is meant to prevent thereby creating a vicious circle. The freedom that residents are denied could result in agitation that confirms the manager's belief in the resident's instability and leads to further restriction. In the context of dementia, 'challenging behaviours' often are assumed to result from cognitive impairment and lack of insight rather than being seen as an adaptive response

to the environments (Boyle, 2008). Therefore, the behaviour of people with dementia often is viewed through the lens of their diagnosis rather than as a valid response to inadequate (social or physical) environments (Boyle, 2008). Such pathologisation of rational human behaviour is a common bias amongst both trained and untrained mental health staff and, beyond care homes, has been noted in other institutional settings (Ilkiw-Lavalle & Grenyer, 2003).

Although care home managers were aware that the consequences of restrictions inevitably included reduced autonomy and impact on quality of life for residents, perhaps individual cost (i.e. risk to the manager) was too great if a fall occurred. As shown by others (Johansson et al., 2009), the fear of residents having falls was a recurrent concern for care home managers. Allowing freedom of movement is an area in which people with dementia (and family members) are more inclined to favour autonomy over safety, compared with professionals who are conscious of negative reactions from others, including litigation (Robinson et al., 2007).

Risk management and safety concerns are embedded in policy and practice, yet so is the enablement of autonomy and choice. Unsurprisingly guidelines often seem confusing. A recent CQC report stated that ‘our biggest overall concern is the safety of care environments’; yet in the same report a home with outstanding care was highlighted for enabling its residents dignity and respect through positive risk-taking (CQC, 2015). Similarly, the DH’s minimum standards for care homes stress the importance of protecting and safeguarding service users (DH, 2006) yet also support risk enablement or positive risk taking (DH, 2010).

It was apparent that competing demands on staff time resulted in prioritisation of physical care needs. Dealing with these physical needs sometimes generated strong negative emotions for residents, especially when physical care was conducted without apparent concern for dignity. Emotional needs often were not considered as important or were seen as inconvenient in the context of limited staff resources. Moreover, providing one-to-one care to meet emotional needs of one particularly vulnerable resident was seen as increasing the risk of harm for other residents. This preoccupation with risk was expressed in an enduring safety discourse that overrode everything else, including implementation of person-centred care. Conversely, prioritising the needs of the group over the individual can lead to a different risk, that of depersonalisation, a state in which the person vanishes and the dementia dominates. Managing individual needs while maintaining a safe care home environment clearly is a

constant dynamic interpersonal process of negotiating and balancing competing interests for care home managers.

There are limits to what we can conclude from this study due to the approach adopted. In particular, the senior staff interviewed will have had some investment in presenting a relatively positive view of their organisation. However, the examples provided indicate a commitment to candour amongst the participants, which supports the integrity of the findings. Care home managers have often been overlooked as a professional group in research despite their skills and leadership attributes being of critical importance to the effectiveness of care in these settings (Orellana et al., 2016). It has been argued that the most effective way of promoting the health and wellbeing of residents is to recruit and retain a good care home manager (Brooker, 2007). A manager's style of management and leadership influences not only the quality of care provided to residents but also the ability to retain staff (Orellana et al., 2016). It is possible that different disciplinary backgrounds and different lengths of service affect how people approach risk and provision of care. However, in this case it was unlikely to have had an impact as, although results were not shown, there was no evidence of an association between type of institution, length of service and qualification type. In this small sample there was a high degree of variability across individuals and these patterns were not identified; but this is not to say that they do not exist. This may be a fruitful area for future research with larger sample sizes or clearer comparative focus. Our findings reflect the realities of care and the ways in which providing care are constructed in this population. Given the need to provide safe and appropriate care for residents of care homes, and in recognition of the complexity of managing the balance between safety and autonomy, it is clear that there is no single strategy that could perfectly address this balance. Evidently there is a need for guidance and support for frontline staff to enable them to use the right approaches to avoid or minimise distress. Although it was evident that staffing levels and insufficient training were issues for some of the participants, further exploration of these needs was not possible with the current data. Residents of care home have increasingly high levels of needs for care and support. This leads to increased staff training needs and a need for higher staffing levels in already over-stretched homes. Clearly, more research is needed to determine optimal staff to resident ratios and which person-centred approaches are most effective in providing safe care for residents. Furthermore, it could be argued that there is a case for the CQC to work more closely with care homes to review how acceptable risk and quality of care are operationalised for this population.

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Table 1: Interview study respondents and care home types

<b>ID</b>	<b>Gender</b>	<b>Age</b>	<b>Professional qualification</b>	<b>Manager</b>	<b>Care home type</b>	<b>Care home size</b>	<b>Provider type</b>
<b>01</b>	Female	55	RGN	Yes	With nursing	Small	Large private
<b>02</b>	Female	45	NVQs	No	Without nursing	Medium	Large private
<b>03</b>	Female	48	RGN/RMN	Yes	With nursing	Medium	Large private
<b>04</b>	Female	54	NVQs	Yes	Without nursing	Small	Not-for-profit
<b>05</b>	Female	56	RGN	Yes	With nursing	Large	Small private
<b>06</b>	Female	38	RNA	No	With nursing	Large	Not-for-profit
<b>07</b>	Male	45	RMN	Yes	With nursing	Medium	Small private
<b>08</b>	Female	52	RGN	Yes	With nursing	Large	Small private
<b>09</b>	Female	46	RGN	No	With nursing	Large	Small private
<b>10</b>	Female	41	NVQs	Yes	Without nursing	Small	Not-for-profit
<b>11</b>	Female	55	RMN	Yes	With nursing	Medium	Large private
<b>12</b>	Female	61	RMN	Yes	With nursing	Large	Small private
<b>13</b>	Female	48	RGN	Yes	With nursing	Small	Small private
<b>14</b>	Female	45	NVQs	Yes	Without nursing	Small	Not-for-profit
<b>15</b>	Female	56	NVQs	Yes	With nursing	Small	Small private
<b>16</b>	Female	43	RGN	Yes	With nursing	Medium	Large private
<b>17</b>	Female	34	NVQs	No	With nursing	Large	Not-for-profit
<b>18</b>	Male	35	RMN	Yes	With nursing	Medium	Small private